		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030304

Facility Name: Four Fountains Convalescent Center

Address: 101 South Belt West (Number) Belleville (City) 62220 (Zip Code)

County: St. Clair

Telephone Number: (618) 277-7700 **Fax #** (618) 277-7363

IDPA ID Number: 37-1182089001

Date of Initial License for Current Owners: 11/4/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Brant **Telephone Number:** 618-277-7700

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2001 to 12-31-2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) David Read, Consultant
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	166	Skilled (SNF)	166	60,590	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,531	26,619	2,416	52,566	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,531	26,619	2,416	52,566	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.76%

D. How many bed-hold days during this year were paid by Public Aid?
186 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/4/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/4/1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,416

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	215,454	30,175	20,267	265,896		265,896		265,896			1
2	Food Purchase		233,646		233,646		233,646		233,646			2
3	Housekeeping	204,612	24,811	5,662	235,085		235,085		235,085			3
4	Laundry	67,419	8,778	4,184	80,381		80,381		80,381			4
5	Heat and Other Utilities			125,870	125,870		125,870		125,870			5
6	Maintenance	58,644	17,387	20,677	96,708		96,708		96,708			6
7	Other (specify):*											7
8	**TOTAL General Services**	546,129	314,797	176,660	1,037,586		1,037,586		1,037,586			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,947,802	256,688	139,665	2,344,155		2,344,155		2,344,155			10
10a	Therapy	40,705		153,475	194,180	(137,459)	56,721		56,721			10a
11	Activities	69,632	6,244		75,876		75,876		75,876			11
12	Social Services	102,225	1,599	11,390	115,214		115,214		115,214			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,160,364	264,531	311,730	2,736,625	(137,459)	2,599,166		2,599,166			16
	C. General Administration											
17	Administrative	141,906		117,007	258,913		258,913		258,913			17
18	Directors Fees											18
19	Professional Services			74,158	74,158		74,158		74,158			19
20	Dues, Fees, Subscriptions & Promotions			35,635	35,635		35,635	(8,979)	26,656			20
21	Clerical & General Office Expenses	81,410	13,170	44,172	138,752		138,752	(100)	138,652			21
22	Employee Benefits & Payroll Taxes			459,652	459,652		459,652		459,652			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,468	5,468		5,468		5,468			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			104,250	104,250		104,250		104,250			26
27	Other (specify):* Non-allowable			26,670	26,670		26,670	(26,670)				27
28	**TOTAL General Administration**	223,316	13,170	867,012	1,103,498		1,103,498	(35,749)	1,067,749			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,929,809	592,498	1,355,402	4,877,709	(137,459)	4,740,250	(35,749)	4,704,501			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Four Fountains Convalescent Center #0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			288,814	288,814		288,814	10,073	298,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			420,773	420,773		420,773	(131)	420,642			32
33	Real Estate Taxes			71,019	71,019		71,019	(5,171)	65,848			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,863	10,863		10,863		10,863			35
36	Other (specify):*											36
37	**TOTAL Ownership**			791,469	791,469		791,469	4,771	796,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,717	6,717	137,459	144,176		144,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,885	90,885		90,885		90,885			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			97,602	97,602	137,459	235,061		235,061			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,929,809	592,498	2,244,473	5,766,780		5,766,780	(30,978)	5,735,802			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,073	30		9
10	Interest and Other Investment Income	(131)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25,570)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(763)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,617)	20		28
29	Other-Attach Schedule sch A	(8,870)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,978)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (30,978)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	medical supplies	x		37,127	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	x		67,428	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule therapies	x		32,904	10a	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 137,459		47

STATE OF ILLINOIS

Four Fountains Convalescent Center

ID# **0030304**

Report Period Beginning: **1-1-2001**

Ending: **12-31-2001**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (100)	21	1
2	PAC dues	(797)	20	2
3	Public Relations	(2,317)	20	3
4	Noncare real estate taxes	(5,171)	33	4
5	Chamber of Commerce	(485)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,870)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,979)	0	0	0	0	0	0	0	0	0	0	(8,979)	20
21	Clerical & General Office Expenses	(100)	0	0	0	0	0	0	0	0	0	0	(100)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(26,670)	0	0	0	0	0	0	0	0	0	0	(26,670)	27
28	**TOTAL General Administration**	(35,749)	0	0	0	0	0	0	0	0	0	0	(35,749)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,749)	0	0	0	0	0	0	0	0	0	0	(35,749)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	10,073	0	0	0	0	0	0	0	0	0	0	10,073	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(131)	0	0	0	0	0	0	0	0	0	0	(131)	32
33	Real Estate Taxes	(5,171)	0	0	0	0	0	0	0	0	0	0	(5,171)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,771	0	0	0	0	0	0	0	0	0	0	4,771	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,978)	0	0	0	0	0	0	0	0	0	0	(30,978)	45

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Four Fountains Associates	100	Columbia Convalescent Center		None		
		Collinsville Care Center				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Steven Brant	Manager	Administrative	2.30	44,350	30	50.00	Salary	$ 59,665	17-1	1
2	Tim Crowley	Director/President	Administrative	0.00	0	8	20.00	Dir Fees	117,007	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 176,672		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 2-31-2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters Bank		X	Mortgage	$52,506.50	4/1/00	$ 5,906,305	$ 5,498,867			$ 420,773	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$52,506.50		$ 5,906,305	$ 5,498,867			$ 420,773	9
	B. Non-Facility Related*											
10								Int income			(131)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (131)	14
15	TOTALS (line 9+line14)						$ 5,906,305	$ 5,498,867			$ 420,642	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 71,019	2
3. Under or (over) accrual (line 2 minus line 1).	$ 71,019	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 71,019	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	50,981	8
1997	55,668	9
1998	67,878	10
1999	72,791	11
2000	71,019	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Four Fountains Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0030304

CONTACT PERSON REGARDING THIS REPORT Steve Brant

TELEPHONE 618-277-7700 FAX #: 618-277-7363

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-28.0-403-001	LOT/SEC-1 PT LYG S OF RICH CR	$ 221.28	$ 221.28
2.	08-28.0-403-002	LOT/SEC-2 PT LYG S OF RICH CR	$ 68.16	$ 68.16
3.	08-28.0-403-003	LOT/SEC-3 PT LYG S OF RICH CR	$ 33.86	$ 33.86
4.	08-28.0-403-004	LOT/SEC-4 PT LYG S OF RICH CR	$ 33.86	$ 33.86
5.	08-28.0-403-055	LOT/SEC 58 PT LTS 57 & 58	$ 65,219.80	$ 65,219.80
6.	08-28.0-403-056	LOT/SEC 58 PT LTS 57 & 58(2701)	$ 5,171.28	$
7.	08-28.0-403-066	LOT/SEC 58 PT LT 58	$ 270.48	$ 270.48
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 71,018.72	$ 65,847.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,562 B. General Construction Type: Exterior Brick Frame Steel Number of Stories one

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	218,250	1985	$ 585,985	1
2					2
3	TOTALS	218,250		$ 585,985	3

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144		1985	1972	$ 3,826,500	$ 120,340	30	$ 127,550	$ 7,210	$ 1,974,575	4
5	22		1996	1996	840,066	25,825	30	28,002	2,177	150,246	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1986	23,852	795	30	795	0	11,527	9
10	Land Improvements			1991	3,947		15	263	263	2,762	10
11	Building Improvements			1987	10,614	354	30	354	(0)	5,133	11
12	Building Improvements			1988	11,664	389	30	389	(0)	5,251	12
13	Building Improvements			1989	192,108	6,404	30	6,404	(0)	78,479	13
14	Parking Lot Repavement			1989	20,043	1,336	15	1,336	0	16,700	14
15	Building Improvements			1990	42,771	1,426	30	1,426	(0)	16,400	15
16	Building Improvements			1991	30,378	1,013	30	1,013	(0)	11,143	16
17	Land Improvements			1991	1,127	75	15	75	0	825	17
18	Building Improvements			1992	11,841	790	30	395	(395)	7,023	18
19	Carpeting			1992	318		7			318	19
20	Land Improvements			1992	3,777	252	15	252	(0)	2,379	20
21	Building Improvements			1993	1,253		7			1,253	21
22	Land Improvements			1993	2,581	173	15	172	(1)	1,510	22
23	Building Improvements			1993	12,614	841	15	841	(0)	7,223	23
24	Building Improvements			1994	6,876	459	15	458	(1)	6,040	24
25	Building Improvements & Land Improvements			1994	40,120	4,014	10	4,012	(2)	26,707	25
26	Building Improvements			1995	16,869	1,125	15	1,125	(0)	7,643	26
27	Building Improvements			1995	33,390	3,340	10	3,339	(1)	22,408	27
28	Architect Fees			1996	65,004	2,167	30	2,167	(0)	23,948	28
29	Landscaping			1996	9,566	638	15	638	(0)	3,509	29
30	Parking Lot			1996	20,700	1,035	20	1,035		5,693	30
31	Roof			1996	77,643	3,882	20	3,882	0	21,351	31
32	Sprinkler System			1996	158,000	10,533	15	10,533	0	57,932	32
33	Wall Coverings			1996	64,986	9,284	7	9,284	(0)	51,062	33
34	HVAC/Electrical			1996	94,899	9,490	10	9,490	(0)	52,195	34
35	Title Recording Fee			1996	73,747	2,458	30	2,458	0	3,724	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Other Construction Costs	1996	$ 106,285	$ 2,717	30	$ 3,543	$ 826	$ 19,487	37
38	Interior Signs, Pipe Line, Shower Dryers	1996	2,522	253	10	252	(1)	1,391	38
39	Alarm Systems	1996	6,242	625	10	624	(1)	3,437	39
40	Window Coverings	1996	14,905	2,981	5	2,981		16,396	40
41	Door, Fire Sprinklers	1996	1,226	82	15	82	(0)	451	41
42	Landscaping, Sewer Tap Fee	1996	12,443	830	15	830	(0)	4,668	42
43	Light Fixtures, Architect Fees (new wing), Plumbing	1996	18,986	633	30	633	(0)	3,482	43
44	Construction Period Interest	1996	25,143	1,676	15	1,676	0	9,218	44
45	Construction Change Orders	1996	2,254	225	10	225	0	1,238	45
46	Carpeting	1996	46,930	1,564	30	1,564	0	8,602	46
47	Hot Water Pipes	1997	1,303	130	10	130	0	542	47
48	Storage Shed	1997	1,002	100	10	100	0	475	48
49	Laundry Water Tank	1997	2,050	205	10	205		1,025	49
50	Remodeling	1998	2,090	139	15	139	0	452	50
51	Replace Asphalt	1998	8,525	853	10	853	(1)	2,630	51
52	Therapy Kitchen	1999	7,500	500	15	500		1,458	52
53	Roof	1999	112,353	7,490	15	7,490	0	20,598	53
54	Shower	1999	1,910	127	15	127	0	350	54
55	Therapy Kitchen	1999	2,802	187	15	187	(0)	483	55
56	Water Heater	1999	9,806	654	15	654	(0)	1,635	56
57	Safe Stride Slip Resistant Floor	1999	480	32	15	32		67	57
58	Asphalt	2000	2,765	138	20	138	0	219	58
59	Sign Lettering	2000	900	45	20	45		68	59
60	Fire Suppresion System	2000	2,259	151	15	151	(0)	357	60
61	Remodeling	2000	22,172	1,478	15	1,478	0	1,721	61
62	New lighting and fixtures	2001	6,360	212	15	212		212	62
63	New drains hall 100	2001	4,843	161	15	161	0	161	63
64	Day room remodel	2001	5,671	189	15	189	0	189	64
65	Dining room remodel hall 500	2001	12,079	403	15	403	(0)	403	65
66	Ansul system hookup	2001	1,900	95	10	95		95	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,142,960	$ 233,313		$ 243,386	$ 10,073	$ 2,676,469	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 740,388	$ 53,428	$ 53,428	$	VAR	$ 312,411	71
72	Current Year Purchases	29,023	2,073	2,073		7	2,043	72
73	Fully Depreciated Assets	811,565					811,565	73
74								74
75	TOTALS	$ 1,580,976	$ 55,501	$ 55,501	$		$ 1,126,019	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,309,921	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 288,814	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 298,887	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,073	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,802,488	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ None	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,863 Description: Dietary-5213; Admin-5650
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39	hrs	$	488	$ 14,314	$	488	$ 14,314	1
2	Licensed Speech and Language Development Therapist	39	hrs		161	6,311		161	6,311	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39	hrs		333	12,279		333	12,279	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				67,428		67,428	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical supplies sold Other (specify): Lab, ambulance					6,717	37,127		6,717	13
14	TOTAL			$	982	$ 39,621	$ 104,555	982	$ 107,049	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12-31-2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 217,438	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	606,460		3
4	Supply Inventory (priced at Cost)	33,847		4
5	Short-Term Investments			5
6	Prepaid Insurance	99,819		6
7	Other Prepaid Expenses	1,886		7
8	Accounts Receivable (owners or related parties)	(2,478)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 956,972	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	585,985		13
14	Buildings, at Historical Cost	6,086,852		14
15	Leasehold Improvements, at Historical Cost	1,340,368		15
16	Equipment, at Historical Cost	296,780		16
17	Accumulated Depreciation (book methods)	(3,842,676)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,467,309	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,424,281	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,117	$	26
27	Officer's Accounts Payable	33,665		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,805		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,594		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	19,208		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Owners Comp	116,051		36
37	Other Accrued Expenses	3,030		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 536,470	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,498,867		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,498,867	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,035,337	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (611,056)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,424,281	$	48

***(See instructions.)**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (702,809)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (702,809)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	91,753	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 91,753	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (611,056)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,416,491	1
2	Discounts and Allowances for all Levels	(40,585)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,375,906	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,267	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 264,267	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,146	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,993	17
18	Sale of Supplies to Non-Patients	75,412	18
19	Laboratory	16,856	19
20	Radiology and X-Ray	5,897	20
21	Other Medical Services	220	21
22	Laundry	605	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 218,129	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	100	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 100	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,858,533	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,037,586	31
32	Health Care	2,736,625	32
33	General Administration	1,103,498	33
	B. Capital Expense		
34	Ownership	791,469	34
	C. Ancillary Expense		
35	Special Cost Centers	6,717	35
36	Provider Participation Fee	90,885	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,766,780	40
41	**Income before Income Taxes (line 30 minus line 40)****	91,753	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 91,753	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. Tax return incomplete**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,080	$ 53,057	$ 25.51	1
2	Assistant Director of Nursing	1,920	2,080	37,787	18.17	2
3	Registered Nurses	16,023	17,145	357,998	20.88	3
4	Licensed Practical Nurses	24,094	26,060	431,653	16.56	4
5	Nurse Aides & Orderlies	89,974	95,779	998,236	10.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,455	3,769	40,705	10.80	8
9	Activity Director					9
10	Activity Assistants	9,704	10,304	69,632	6.76	10
11	Social Service Workers	6,281	7,041	102,225	14.52	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	28,727	13.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,787	23,797	186,727	7.85	15
16	Dishwashers					16
17	Maintenance Workers	4,211	4,571	58,644	12.83	17
18	Housekeepers	24,650	26,730	204,612	7.65	18
19	Laundry	7,996	8,751	67,419	7.70	19
20	Administrator	1,920	2,080	82,241	39.54	20
21	Assistant Administrator					21
22	Other Administrative	1,560	1,560	59,665	38.25	22
23	Office Manager					23
24	Clerical	12,106	13,473	150,481	11.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,521	247,300	$ 2,929,809 *	$ 11.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	479	$ 12,460	1-3	35
36	Medical Director	monthly	7,200	9-3	36
37	Medical Records Consultant	8	280	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	720	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	503	7,670	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,011	$ 28,330		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2,721	76,269	10-3	51
52	Nurse Aides	3,501	56,457	10-3	52
53	TOTAL (lines 50 - 52)	6,222	$ 132,726		53

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steven Brant	Administrative	2.3%	$ 59,665
Hope McNitt	Administrator	0	82,241
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 141,906

B. Administrative - Other

Description	Amount
Tim Crowley	$ 117,007
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 117,007

C. Professional Services

Vendor/Payee	Type	Amount
Blue and Company	Accounting	$ 5,088
J.W. Boyle & Co. Ltd.	Accounting	16,022
Rubin Brown & Gornstein LLP	Auditing	17,000
SAMAS	Bookkeeping	75
Jennings, Jacknewitz	legal	8,532
Greensfelder, Hemker	legal	120
Van Ostrand, Elvidge	legal	2,935
Wessels, Pautsch	legal	50
Duane Morris	legal	24,116
SAMAS	legal	220
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 74,158

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,442
Unemployment Compensation Insurance	18,193
FICA Taxes	218,494
Employee Health Insurance	92,448
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K	6,017
Other misc benefits	7,058
TOTAL (agree to Schedule V, line 22, col.8)	$ 459,652

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	16,401
Health Care Worker Background Check	552
(Indicate # of checks performed 46)	
Illinois Health Care Assoc	8,749
Lobbying, Advertising , Public relations	8,494
Misc dues and subscriptions	549
Misc fees	205
Less: Public Relations Expense	(3,114)
Non-allowable advertising	(763)
Yellow page advertising	(4,617)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,656

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	353
Seminar Expense	5,115
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,468

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Four Fountains Convalescent Center # 0030304 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **8749**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,505** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **90,885**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **n/a** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Rubin Brown & Gornstein** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Page 1

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
General Services:			
Dietary			
Uniforms			642
Wages	215454		
Supplies		30175	
Consultant			12461
Repairs			1110
Temporary Services			5681
Special events			373
Total Dietary	215454	30175	20267
Food Purchase			
Food		218569	
Supplements		15077	
Total Food Purchase	0	233646	0
Housekeeping			
Wages	204612		
Supplies		24811	
Temporary Services			5662
Total Housekeeping	204612	24811	5662
Laundry			
Wages	67419		
Supplies		8778	
Linens			4112
Equipment			
Temporary Services			72
Total Laundry	67419	8778	4184
Page Totals	487485	297410	30113

Page 2

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
General Services:			
Heat & Other Utilities			
Utilities			125488
Cable TV Lobby			382
Total Heat & Other Utilities	0	0	125870
Maintenance			
Uniforms			52
Repairs			19729
Wages	58644		
Supplies		17387	
Temporary Services			896
Total Maintenance	58644	17387	20677
Other (Specify)			
Total Other	0	0	0
Health Care & Programs			
Medical Director			
Fees			7200
Total Medical Director	0	0	7200
Page Totals	58644	17387	153747

Page 3

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
Health Care & Programs			
Nursing & Medical Records			
DON	53057		
ADON	37787		
Admin Nursing Wages	141825		
Wages - RN	216173		
Wages - LPN	431653		
Wages - Aides	998236		
Wages Unit Secretaries	69071		
Temporary Services			194
Uniforms			3333
Lab Consultant			110
Drugs		70855	
Department Supplies		2530	
MR Cons.			280
Pharm. Cons.			720
Oxygen		5430	
Agency Staff			132726
Diapers		56505	
Medical Supplies		120432	
Equipment			2302
Wages Rehab	40705		
PT Contract			96520
ST Contract			10970
OT Contract			45985
Therapy Beds		936	
Total Nurs. & Medical Records	1988507	256688	293140
Activities			
Wages	69632		
Supplies		6244	
Total Activities	69632	6244	0
Page Totals	2058139	262932	293140

Page 4

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
Health Care & Programs			
Social Services			
Marketing Consultant			3720
Wages	102225		
Consultant			7670
Supplies		1599	
Total Social Services	102225	1599	11390
Nurse Aide Training			
Total Nurse Aide Training	0	0	0
Program Transportation			
Total Prog. Transportation	0	0	0
Other (Specify)			
Total Other	0	0	0
General Administration			
Administrative			
Salary	141906		
Owners Compensation			117007
Total Administrative	141906	0	117007
Page Totals	244131	1599	128397

Page 5

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
General Administration			
Directors Fees			
Total Directors Fees	0	0	0
Professional Services			
Legal Fees			35973
Accounting			38185
Total Prof. Services	0	0	74158
Fees,Subscriptions & Promotions			
Dues & Subs			9783
PAC Dues			797
Advertising			763
Yellow Pages			4617
Help Wanted			16401
Licenses			405
Background Checks			552
Public Relations			2317
Total Fees, Subs & Promotions	0	0	35635
Clerical & Gen. Office Exp.			
Salaries	81410		
Miscellaneous			238
Repairs office equipment			1936
Postage			6189
Telephone			10974
Temporary Sevices			1593
Admin. Consultants			2957
Office Supplies		12642	
Service Fees			118
Office Forms		528	
Software Support			5506
Payroll DP Fees			9907
Cell Phone			2811
Auto Expense			1943
Total Clerical & Gen.Office Exp.	81410	13170	44172
Page Totals	81410	13170	153965

Page 6

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
General Administration			
Emp. Benefits & Payroll Taxes			
FICA			213334
U.C. Ins.			18193
Workers Comp.			117442
Health Ins.			92448
401K Plan Costs			6017
Employee Benefits			6677
FICA Admin			5160
Employee Physicals			40
Name Badges			341
Total Emp. Ben. & Payroll Taxes	0	0	459652
Inservice Training & Education			
Administration			
Total Ins. Training & Education	0	0	0
Travel & Seminar			
Seminar Cost			5115
Meals & Travel			
Auto Costs(Milage)			353
Total Travel & Seminar	0	0	5468
Other Adm. Staff Transportation			
Total Other Adm. Transp.	0	0	0
Page Totals	0	0	465120

Page 7

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification	Salary/Wage	Supplies	Other
General Administration			

	Salary/Wage	Supplies	Other
Package Ins Prop & Liab.			104250
Auto Ins.			
Total Ins.Prop.Liab.Malpractice	0	0	104250
Other (specify)			
Contributions			1100
Sales Tax			25570
Total Other	0	0	26670
Ownership			
Depreciation			
Depr.			288814
Total Depreciation	0	0	288814
Amortization of Pre-Op.&Org.			
Total Amort. Of Pre-Op. & Org.	0	0	0
Interest			
Interest Mortgage			420247
Loan Amort			526
Total Interest	0	0	420773
Page Totals	0	0	840507

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification Ownership	Salary/Wage	Supplies	Other
Real Estate Taxes			
RE Taxes			71019
Total Real Estate Taxes	0	0	71019
Rent-Facility & Grounds			
Total Rent-Facility & Grounds	0	0	0
Rent-Equipment & Vehicles			
Office			5650
Dietary			5213
Total Rent-Equip & Vehicles	0	0	10863
Other (specify)			
Total Other	0	0	0
Special Cost Centers			
Medically Necessary Transportation			
Total Med. Nec. Transp.	0	0	0
Page Totals	0	0	81882

Facility: Four Fountains Convalescent Center
FYE: December 31, 2001

Classification Special Cost Centers	Salary/Wage	Supplies	Other
Ancillary Service Center			
Lab & X-Ray			5619
Ambulance			603
Doctor VA			495
Total Ancillary Serv. Ctr	0	0	6717
Barber & Beauty Shops			
Total Barber & Beauty Shops	0	0	0
Coffee & Gift Shops			
Total Coffee & Gift Shops	0	0	0
Provider Participation Fee			
IDPA Assesment			90885
Total Prov. Participation Fee	0	0	90885
Other (specify)			
Income Taxes			
Total Other	0	0	0
Page Totals	0	0	97602
Grand Total	2929809	592498	2244473
1+2+3 = Total Expenses per WTB			
Total Per WTB $ 5,766,780_________	1	2	3

Grand Total 5766780

Medicare Worksheet: **12/31/2001**

Revenue Summary

Routine		$5,416,491			
Medical Supplies		$74,256	Cost	$37,127	
Drugs		$107,993	Cost	$67,428	
Physcial Therapy		$149,399			
X-Ray		$5,897			
Occupational Therapy		$105,913			
Speech Therapy		$8,955	**Therapy**	**$264,267**	
Laboratory		$16,856			
Physician		$220		**Total Anc.**	**$469,489**
Cable TV			Offset Cost		
Beauty Shop Net income		$11,146	Separate Cost Center		
Laundry		$605			
Interest		$131	Offset		
Meal Income			Offset		
Donations			No Offset		
Misc.		$100	Offset		
Vending			Separate Cost Center		
	Bad Debts	($320)			
	Contractuals	($40,265)			
	Net Revenue	**$5,857,377**	**Expenses**	**$5,766,780**	